

**STATE BOARD OF PHARMACY**

800 SW Jackson, Suite 1414
Topeka, Kansas 66612-1244
www.pharmacy.ks.gov (785)296-4056

**REGISTRATION APPLICATION:
Non-Resident Pharmacy
Form BA-22**

All applications must be typed, be complete, and include all fees and supporting documentation before they will be processed by staff.

FEES

Enclose a check or money order payable to the Kansas State Board of Pharmacy in the amount of \$112.00. Fees are nonrefundable.

RESIDENT STATE

Attach a copy of your current pharmacy registration and an official license verification from your home-state indicating that the pharmacy is actively licensed and in good standing with the Board of Pharmacy. Also attach the most recent inspection report conducted within the past two years by the state of residence.

OWNERSHIP

The Owner is considered the "applicant" for purposes of this form. If the Owner is a corporate or other legal entity, please complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate).

Please indicate if this is a new application or a change:

☐ New Application

Change (Check all that apply): ☐ Address

☐ Ownership

☐ Name

Previous registration number: _____ Effective date of change: _____

OWNER/APPLICANT INFORMATION

| | | | |
|---|-------|-----------------------------------|--------|
| Name | | Other States Registered (abbrev.) | |
| Address | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |
| Ownership Type: <input type="checkbox"/> Individual Provide SSN: _____ <input type="checkbox"/> Government Entity Provide FEIN: _____ <input type="checkbox"/> Partnership <input type="checkbox"/> LLC <input type="checkbox"/> Corporation Complete and attach the appropriate Ownership Form (S-310 Partnership, S-320 LLC, or S-330 Corporate) | | | |

PHARMACY INFORMATION

| | | | |
|---|---------------------|---|-----------------|
| Name | | | |
| Physical Address (non-residential, no PO Box) | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |
| Resident State | Registration Number | Original Issue Date | Expiration Date |
| Website | | Can patients purchase prescriptions online? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| Toll Free Phone Number | | Store/Facility Hours | |
| Pharmacy Hours of Operation | | Hours/Week Pharmacist on Duty | |

Initials: _____

OFFICE USE ONLY

Permit #: _____ Fee: \$ _____ Date: _____ Check #: _____

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| | | | |
|---------|-------|-------|--------|
| Name | | Title | |
| Address | | | |
| City | State | Zip | County |
| Phone | Fax | | Email |

Designate where all formal correspondence, notices, and renewals should be sent:

☐ Owner ☐ Physical Location ☐ Authorized Agent

PHARMACIST-IN-CHARGE

| | | |
|-------|----------------|-----------------|
| Name | License Number | Licensure State |
| Phone | Fax | Email |

PHARMACY TYPE (Check all that apply)

☐ Retail – Chain ☐ Mail Order
☐ Retail – Independent ☐ Other: _____

DRUG SCHEDULES (Check all that apply)

☐ Schedule II narcotic ☐ Schedule IV
☐ Schedule II non-narcotic ☐ Schedule V
☐ Schedule III narcotic ☐ Other: _____
☐ Schedule III non-narcotic

☐ Yes ☐ No **Is the applicant currently registered by the DEA to possess the controlled substances selected above?**

If yes, attach a copy of the current DEA Registration.

Current DEA Registration Number _____ Expiration Date _____

If no, is there an application currently pending (provide application date)? _____

☐ Yes ☐ No **Does the pharmacy perform any compounding?** If yes, select all that apply: ☐ Sterile ☐ Non-sterile

DISCIPLINARY INFORMATION

Applicant includes the legal ownership entity as well as each individual, owner, partner, corporate officer, or director.

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 1. Has the applicant or any pharmacist employed by the applicant been convicted of any violation of the federal Food, Drug and Cosmetic Act? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 2. Has the applicant been convicted under any federal, state, or local law relating to drug samples, wholesale or retail drug distribution, manufacturing, dispensing, or distribution of any drug or controlled substance? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 3. Has the applicant or the PIC been convicted of any felony or drug-related misdemeanor? |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | 4. Has any license or registration, currently or previously held by the applicant or the PIC been surrendered to, denied, disciplined, censured, suspended, limited, placed on probation, or revoked by any state or federal government? |

If yes to any of the above questions, please attach Form S-300: Disciplinary History.

☐ Yes ☐ No **5.** Has the applicant complied with all registration requirements under any previous or current licenses or registrations?

If no to the above question, please attach a detailed explanation along with any relevant documentation.

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**REGISTRATION APPLICATION:
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Form BA-22****LICENSED PHARMACISTS** (List all pharmacists working in the non-resident pharmacy. Attach additional pages if needed.)

| | | |
|------|----------------|-------|
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
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| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |
| Name | License Number | State |

PIC CERTIFICATION

I declare under penalty of perjury under the laws of the State of Kansas that I am the pharmacist-in-charge acting on behalf of the applicant, and I hereby accept responsibility for operating in compliance with all state and federal laws, which shall include compliance with the Kansas Pharmacy Act and Kansas Controlled Substances Act.

SIGNATURE_____
DATE SIGNED**OWNER/APPLICANT CERTIFICATION**

I declare under penalty of perjury under the laws of the State of Kansas that I have read and understand this application and that the information provided is true, correct, and complete to the best of my knowledge.

SIGNATURE_____
DATE SIGNED